Medtronic
Engineering the extraordinary

Basivertebral Nerve Ablation Patient access resource

March 2026

Disclaimer
Medtronic provides this information for your convenience only. It does not constitute legal advice or a recommendation regarding clinical practice. Information provided is gathered from third-party sources and is subject to change without notice due to frequently changing laws, rules and regulations. The provider has the responsibility to determine medical necessity and to submit appropriate codes and charges for care provided. Medtronic makes no guarantee that the use of this information will prevent differences of opinion or disputes with Medicare or other payers as to the correct form of billing or the amount that will be paid to providers of service. Please contact your Medicare contractor, other payers, reimbursement specialists and/or legal counsel for interpretation of coding, coverage and payment policies. This document provides assistance for FDA approved or cleared indications. Where reimbursement is sought for use of a product that may be inconsistent with, or not expressly specified in, the FDA cleared or approved labeling (e.g., instructions for use, operator's manual or package insert), consult with your billing advisors or payers on handling such billing issues. Some payers may have policies that make it inappropriate to submit claims for such items or related service.

Document overview and resources

Overview

This document outlines resources available to support patient access to Basivertebral Nerve Ablation (BVNA). Click on the links below to access resources within this document.

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Medicare coverage landscape and medical necessity

Medicare prior authorization: Not required

Medicare does not require prior authorization for Basivertebral Nerve Ablation (BVNA)

Medicare Administrative Contractors (MAC) coverage landscape

Two MACs have Local Coverage Determinations (LCDs) and Local Coverage Articles (LCAs) for Basivertebral Nerve Ablation (BVNA) that are broadly similar; however it is recommended to check your specific MAC's criteria. One MAC has a proposed LCD policy that is not yet finalized (as of March 2026). All other MACs are silent.

Jurisdiction & States Covered	MAC	Local Coverage Determination (LCD)	BIlling and Coding Article
J6: IL, MN, WI JK: CT, ME, MA, NH, NY, RI, VT	NGS	Link (PROPOSED)	Link (PROPOSED)
JE: CA, HI, NV JF: AK, AZ, ID, MT, ND, OR, SD, UT, WA, WY	Noridian	Link	Link
JM: NC, SC, VA, WV JJ: AL, GA, TN	Palmetto	Link	Link

Noridian LCD/LCA requirement sample checklist

Intraosseous Basivertebral Nerve Ablation L39642

Medical policies last accessed **February 2026.** Requirements are subject to change without notice. The policy outlines specific details regarding criteria and limitations to meet medical necessity. This sample checklist is intended to be a resource. Please review the entire LCD and Local Coding Article.

Coverage criteria and documentation requirements

Thermal ablation of the intraosseous Basivertebral Nerve (BVN) is considered medically reasonable and necessary for the treatment of Chronic Low Back Pain (CLBP) in patients who meet **ALL** the following criteria for coverage and reimbursement:

- Skeletally mature and has had CLBP for at least 6 months, with lower back pain as the dominant symptom.
- Failed to adequately improve despite documented non-surgical management, to include at least 3 or more of the following:
  - Avoidance of activities that aggravate pain
  - Course of physical therapy or professionally directed therapeutic exercise program
  - Chiropractic manipulation
  - Cognitive therapy
  - Pharmacotherapy, including narcotic and non-narcotic analgesics, muscle relaxants, neuroleptics, and anti-inflammatories
  - Injection therapy of epidural or facet joint implicated pain sources in the region of concern
- Type 1 or Type 2 Modic changes on MRI: Endplate hypointensity (Type 1) or hyperintensity (Type 2) on T1 images plus hyperintensity on T2 images (Type 1) involving the endplates between L3 and S1.
- Absence of additional vertebral pathology by physical, history, radiologic or clinical assessment including, but not limited to fracture, tumor, infection, deformity, trauma, or post-surgical change which could cause the patient's symptoms or complicate the procedure and outcome.
- Physical and psychological assessment of patient's ability to tolerate and benefit from BVN ablation.

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Intraosseous Basivertebral Nerve Ablation L39642 (continued)

Contraindications

The following conditions are considered **relative** contraindications. Documentation in the patient's medical record must explain the precautionary provisions taken for the individual patient to preclude anticipated or potential adverse events secondary to treatment.

- Skeletal immaturity (<18 years of age)
- Evidence on imaging (MRI, flexion/extension radiographs, CT) of another etiology for LBP symptoms, including, but not limited to, lumbar spinal stenosis, spondylolisthesis, segmental instability, disc herniation, degenerative scoliosis, facet arthropathy or effusion with clinically suspected facet joint pain
- Metabolic bone disease (e.g., osteoporosis with T score <-2.5), treatment of spine fragility fracture, trauma/compression fracture, or spinal primary or metastatic tumor
- Active spine or systemic infection
- Neurogenic claudication, lumbar radiculopathy, radicular pain, nerve impingement or compression (e.g., NHP, stenosis), as primary symptoms
- Patients with severe cardiac or pulmonary compromise, systemic vulnerability to bleeding, or concern for further compromise of existing disease
- Patients with imlantable pulse generators (e.g., pacemakers, defibrillators, or neurostimulator) and other electronic implants, unless type specific precautions are taken to maintain patient safety
- Ongoing use of abuse of addictive medications without evidence of potential weaning or decreased use with treatment

Limitations

- No previous history of BVN ablation at the planned level of treatment
- No more than one to two (1-2) vertebral bodies may be treated at a single session
- Treatment of no more than 4 vertebral bodies per patient lifetime
- Treatment is within the confines of L3-S1 vertebral bodies
- Retreatment of a single vertebral body with BVN ablation within the patient's lifetime is not considered reasonable and necessary
- Local anesthesia is considered appropriate for the region treated. Mild sedation may be administered by the performing physician or staff under his direction but should not be coded separately. Additional anesthesia services may not be billed separately without documentation of medical necessity

Palmetto LCD/LCA requirement sample checklist

Thermal Destruction of the Intraosseous Basivertebral Nerve (BVN) for Vertebrogenic Lower Back Pain L39420

Medical policies last accessed **February 2026.** Requirements are subject to change without notice. The policy outlines specific details regarding criteria and limitations to meet medical necessity. This sample checklist is intended to be a resource. Please review the entire LCD and Local Coding Article.

Covered Indications

Thermal destruction of the intraosseous BVN will be considered medically reasonable and necessary for the treatment of cLBP in patients who meet **ALL** the following criteria:

- Chronic lumbar back pain of ≥6 months duration that causes functional deficit measured on a pain or disability scale (pain assessment and a disability scale must be obtained at baseline to be used for functional assessment), **AND**
- Documented failure to respond to ≥6 months of non-surgical management, **AND**

  Non-surgical management may include but is not limited to:
  - Avoidance of activities that aggravate pain
  - Trial of Chiropractic manipulation
  - Trial of Physical Therapy
  - Cognitive support and recovery reassurance
  - Injection therapy – epidural and/or facet
  - Spine biomechanics education
  - Specific lumbar exercise program
  - Home use of heat/cold modalities
  - Low impact aerobic exercise as tolerated
  - Pharmacotherapy (e.g., non-narcotic analgesics, NSAIDs, muscle relaxants, neuroleptics, and narcotics).
- Absence of non-vertebrogenic pathology per clinical assessment or radiology studies that could explain the source of the patient's pain, including but not limited to fracture, tumor, infection, or significant deformity, **AND**
- Evidence of Type 1 or Type 2 Modic changes on MRI, such as inflammation, edema, vertebral endplate changes, disruption and fissuring of the endplate, vascularized fibrous tissues within the adjacent marrow, hypotensive signals (Type 1 Modic change), and changes to the vertebral body marrow including replacement of normal bone marrow by fat, and hypertensive signals (Type 2 Modic change), in 1 or more vertebrae from L3-S1.

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Thermal Destruction of the Intraosseous Basivertebral Nerve (BVN) for Vertebrogenic Lower Back Pain L39420 (continued)

Patients must have undergone careful screening, evaluation, and diagnosis by a multidisciplinary team prior to thermal destruction of the intraosseous BVN (such screening must include psychological, as well as, physical evaluation). Documentation of the history and careful screening must be available in the patient chart if requested.

Limitations

Services that are not reasonable and necessary cannot be covered by Medicare in the following:

- Skeletally immature patients (≤18 years old)
- Severe cardiac or pulmonary compromise
- Active systemic infection or local infection at the intended treatment level
- Bleeding diathesis
- Pregnancy
- Primary radicular pain into the lower extremities (defined as nerve pain following a dermatomal distribution and that correlates with nerve compression on imaging)
- Previous lumbar/lumbosacral spine surgery at the intended treatment level (with the exception of discectomy/laminectomy if performed >6 months prior to BVN nerve ablation and radicular pain resolved)
- Primary symptomatic lumbar or lumbosacral spinal stenosis (defined as the presence of neurogenic claudication and confirmed by imaging)
- Diagnosed osteoporosis (T-score of -2.5 or less), spine fragility fracture history, trauma/compression fracture at the intended treatment level, or spinal cancer
- Radiographic evidence of any of the following that correlates with predominant physical complaints:
    a. Lumbar/lumbosacral disc extrusion or protrusion >5mm at levels L3-S1
    b. Lumbar/lumbosacral spondylolisthesis > 2mm at any level
    c. Lumbar/lumbosacral spondylolysis at levels L3-S1
    d. Lumbar/lumbosacral facet arthrosis/effusion correlated with facet-mediated pain at levels L3-S1
- BMI >40
- Advanced generalized systemic disease that limits quality-of-life (QOL) improvements would require a statement of the objective of treatment in such cases
- Active, untreated substance abuse disorder.

NOTE: Thermal destruction of the intraosseous BVN must only be performed once per vertebral body from L3-S1 per lifetime. Up to 4 vertebral bodies may be treated during 1 procedure.

Documentation best practices

Physician documentation

The following is a list of information payers commonly look for when reviewing for medical necessity. When available, the payer policy should also be referenced.

- Thorough description of low back pain:
  - Duration of pain
  - Clinical and/or radiographic absence of non-vertebrogenic pathology
  - Visual Analog Scale (VAS) and functional score
  - Impact to activities of daily living
  - Oswestry Disbaility Index (ODI) functional impairment score
- Previous conservative medical management (CMM) treatments tried and deemed unsatisfactory (e.g. pharmacotherapy, physical therapy, cognitive support/therapy, epidural/facet injections, etc.). Include treatment duration/number of sessions and description of pain/functional response.
- MRI report with evidence of Modic Type I or Type II changes (and specific vertebral body/bodies)
- Address the benefit/risk profile of any potential relative contraindications
- Past lumbar spine surgeries-confirm none at same spinal level proposed for BVNA
- Mental health statement or psychological screening
- Document the specific vertebral body(ies) to be treated
- State clinical and radiographic findings that confirm the primary pain generator at the proposed level of treatment is the BVN, and not other conditions. If other conditions (such as spondylolisthesis, spondylolysis) are present in imaging explain why these are not the primary pain generator.
- Additional comments (why BVNA is the best treatment option)

Please note: This information is provided for consideration only. It does not constitute legal advice or a recommendation regarding clinical practice. The provider is responsible for determining medical necessity and submitting appropriate documentation for care being provided. Please contact the payer for policy and coverage requirements. Use of this guide does not guarantee authorization or payment.

Prior authorization process

Predetermination, preauthorization, precertification, clinical review, prior approval, preservice review, or advanced benefit notification are all terms used to describe a utilization management process leveraged by payers to evaluate medical necessity and determine if certain products or services will be covered. This process requires providers to obtain advanced approval that medical necessity and coverage criteria have been met before services are provided. Prior authorization may take over 2 weeks, not including the appeal process. It is recommended providers consider this when scheduling the procedure.

1

Collect information

- Patient consent release
- Benefit plan information
- Patient specific clinical documentation (diagnosis, procedure, and place of service codes and descriptions)
- Date of service (requesting a date range allows flexibility in scheduling and may prevent the need to resubmit your prior authorization request should a procedure be rescheduled). Please note: If prior authorization is approved, but the procedure is not performed within the date range requested, your claim may be denied.

2

Contact the payer

- Verify patient eligibility, benefits, and out-of-pocket costs (e.g. co-pay, deductible and out-of-pocket maximum)
- Verify physician and facility network contract status.
- Verify and inquire about the medical policy coverage requirements for the procedure. It is not uncommon for payers to be silent (to have no policy that specifically includes or excludes coverage). Some payers may have a non-coverage policy. In these cases, prior authorization is strongly recommended and allows providers to request a coverage exception.
- Determine payer requirements for prior authorization. If prior authorization is not required, inquire if a predetermination or courtesy review is available. If not, document the date of your call, who you spoke with, and the call reference number if available. Please note, the likelihood of a claim denial if a pre-service review is not performed especially if a non-coverage policy exists.

3

Submit the request

- Determine the payer's prior authorization submission method: fax, phone, payer portal, email, or mail. Track submission method for future prior authorization requests.
- Submit letter of medical necessity if necessary.
- Gather and submit all supporting materials such as the information in Step 1, any payer required prior authorization forms, and supporting medical documentation (e.g., prescription, letter of medical necessity, medical records).

Prior authorization process

4

Follow-up

- Contact the payer within a few days of submission to confirm receipt of PA request and if all the information has been received. If available, document and obtain the reference number for the call.
- Document your payer interactions, including date, time, name of contact person, and call reference number.
- Prior authorization approval can generally take between 3-30 days.
- If approved, document approval number.

5

Verify eligibility

- If the prior authorization is approved, obtain the prior authorization number and request the approval letter. Re-verify the patient's eligibility to ensure they are still covered.
- If the prior authorization is denied, request the denial letter to determine the payer's rationale and appeal process. Inquire about a peer-to-peer option.

Only continue to the next step if the prior authorization is denied.

6

Appeal

- Request a copy of the denial in writing.
- Refer to PA denial letter for rationale & appeal instructions.
- Confirm the patient and physician want to appeal the denial.
- Prepare the appeal, addressing the denial reason and include any new supporting medical documentation. If requesting a reconsideration, new information is typically required.
- If the prior authorization is denied, the payer may allow a peer-to-peer review. Please contact the payer to inquire about this option.

In many cases, there is only one first level appeal available. An appeal can be submitted by the provider or patient. Patients may contact Member Services at the phone number on the back of their insurance card or their employer for assistance.

7

Subsequent appeals

- Refer to the denial letter for next level appeal options (some payers may offer different level of appeal options and escalation).
- Generally, commercial payers offer a second level appeal (within 60 days) followed by an external review (within 120 days). An external review, also referred to as an independent medical review, is a final appeal submitted to a third-party review organization.
- For Medicare Advantage plans, the first appeal will automatically be sent to an Independent Review Entity (IRE) for a second level appeal; providers can submit additional information to the IRE within 10 days. If the second level appeal is denied, you may request review by the Office of Medicare Hearing and Appeals.[1] This will involve a hearing before an Administrative Law Judge. For additional appeal rights, please contact the payer or the Centers for Medicare & Medicaid Services (CMS).[1]

1. Medicare. Medicare.gov: the official U.S. government site for Medicare | Medicare. Medicare.gov. Published 2024. https://www.medicare.gov/

Prior authorization resources

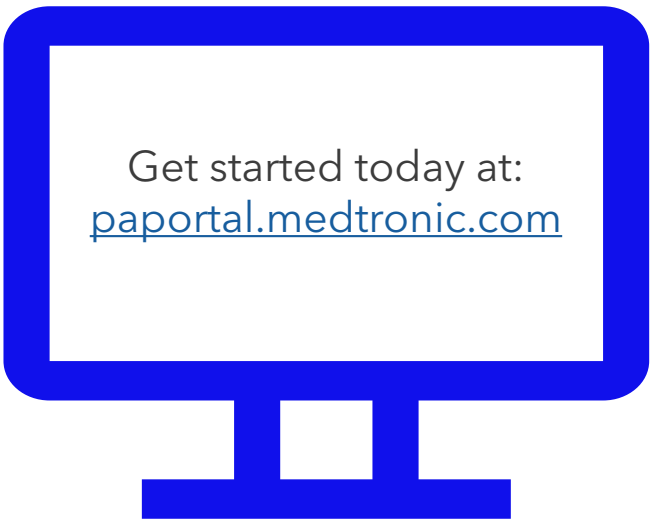
Patient Access Support (PAS)

Patient Access Support (PAS) is available to facilitate patient access to Medtronic Pain Interventions products and therapies by providing HCPs who request PAS on behalf of their patients with assistance in obtaining patient coverage decisions from payers.

Patient Access Connect (PAC)

The Medtronic Patient Access Connect (PAC) is a digital solution for streamlining the prior authorization process so patients can access Pain Interventions products and therapies more efficiently.

- Simple submissions: Leverage an intuitive, user-friendly interface.
- Real-time case tracking: Monitor progress of submissions in real time.
- Automated notifications: Receive instant updates and notifications for case statuses.
- Centralized case access: Access prior authorization records from one convenient location.
- Data insights: Gain insights into submission trends and approval rates.



Sample letter templates

Instructions

These documents are sample letter templates that providers can use as a guide to create a patient-specific letter for prior authorization or appeal. To be effective, the letter **must be customized to the specific circumstances of each patient and his/her payer.** The requesting provider is responsible for ensuring accuracy and adequacy of all information provided. Use of these templates does not guarantee authorization or payment.

- Please do not include this instruction page to avoid misinterpretation of your request as a form letter.
- It is recommended that providers use their business letterhead as appropriate.
- Please customize the letter using information pertinent to yourself, your patient, and his/her condition/procedure. All letter content can be edited.
- This letter is not intended to replace any professional judgement; it is merely to assist with the prior authorization or appeal request. Providers are encouraged to include their professional expertise and experience with this procedure.
- It is important to contact the patient's insurance for prior authorization or appeal timelines, submission processes, and requirements.

Sample letter of medical necessity

Provide the following information in the heading of the letter:
Date, Payer Name, Address and Phone Number, Patient Name, Policy Holder, ID#, Group #, Social Security or Patient Identification # and Date of Birth

To Whom It May Concern,

On behalf of my patient, **[patient name]**, I am writing to request prior authorization for Basivertebral Nerve Ablation (BVNA), a procedure that I have deemed medically necessary for the treatment of chronic vertebrogenic low back pain.

Basivertebral Nerve Ablation (BVNA) is a minimally invasive interventional procedure that uses thermal ablation of the basivertebral nerve (BVN) to treat vertebrogenic pain.

Explain the clinical rationale leading to the decision to recommend Basivertebral Nerve Ablation (BVNA). You may require one or more paragraphs to address the following:

- Thorough description of low back pain:
  - Duration of pain
  - Clinical and/or radiographic absence of non-vertebrogenic pathology
  - Visual Analog Scale (VAS) and functional score
  - Impact to activities of daily living
  - Oswestry Disability Index (ODI) functional impairment score
- Previous conservative medical management (CMM) treatments tried and deemed unsatisfactory (e.g. pharmacotherapy, physical therapy, cognitive support/therapy, epidural/facet injections, etc.). Include treatment duration/number of sessions and description of pain/functional response.
- MRI report with evidence of Modic Type I or Type II changes (and specific vertebral body/bodies)
- Address the benefit/risk profile of any potential relative contraindications
- Past lumbar spine surgeries – confirm none at same spinal level proposed for BVNA
- Mental health statement or psychological screening
- Document the specific vertebral body(ies) to be treated
- State clinical and radiographic findings that confirm the primary pain generator at the proposed level of treatment is the BVN, and not other conditions. If other conditions (such as spondylolisthesis, spondylolysis) are present in imaging explain why these are not the primary pain generator.
- Additional comments (why BVNA is the best treatment option)

Clinical evidence
There is considerable evidence to support the use of BVNA for treatment of chronic vertebrogenic low back pain. The first randomized double-blind sham-controlled multicenter study published on BVNA involving 225 patients showed that 75.6% of treated patients vs. 55.3% in the sham arm achieved the minimum clinically important difference (MCID) of at least a 10-point change in functional improvement as measured by the Oswestry Disability Index (ODI) at 3 months.[1] Long-term follow-up results confirmed improvements in pain and functioning were sustained at 24 months and five years post-treatment.[2,3] A second RCT evaluating BVNA confirmed that a significantly greater proportion of treated patients achieved at least the MCID improvement in ODI in the ablation arm (74.5%) vs the standard-care arm (32.7%, P<.001) at 3 months, with results sustained at 24 months.[4,5]

Sample letter of medical necessity

In closing, I have determined that **Basivertebral Nerve Ablation (BVNA)** is not only medically necessary but the most appropriate treatment for my patient for which I have provided the above and enclosed information to support this request. As such, I respectfully request prior authorization for this procedure. If you have any questions, please contact me at **[phone number]**. Thank you for your prompt review.

Sincerely,
_____, MD

Provider name
Provider NPI/Tax ID

Enclosed: **List of enclosures (e.g., prescriptions, copies of pertinent medical records, along with any other relevant information you believe would make a persuasive argument for coverage such as clinical evidence).**

1. Fischgrund JS, Rhyne A, Franke J, et al. Intraosseous basivertebral nerve ablation for the treatment of chronic low back pain: a prospective randomized double-blind sham-controlled multi-center study. Eur Spine J. 2018; 27(5):1146-1156.
2. Fischgrund JS, Rhyne A, Franke J, et al. Intraosseous basivertebral nerve ablation for the treatment of chronic low back pain: 2-year results from a prospective randomized double-blind sham-controlled multicenter study. Int J Spine Surg. 2019; 13(2):110-119. PMID 31131209
3. Fischgrund JS, Rhyne A, Macadaeg K, et al. Long-term outcomes following intraosseous basivertebral nerve ablation for the treatment of chronic low back pain: 5-year treatment arm results from a prospective randomized double-blind sham-controlled multi-center study. Eur Spine J. 2020; 29(8):1925-1934.
4. Khalil JG, Smuck M, Koreckij T, et al. A prospective, randomized, multicenter study of intraosseous basivertebral nerve ablation for the treatment of chronic low back pain. Spine J. 2019;19(10):1620-1632
5. Koreckij T, Kreiner S, Khalil J, et al. Prospective, randomized, multicenter study of intraosseous basivertebral nerve ablation for the treatment of chronic low back pain: 24-month treatment arm results. NASSJ. 2021;8:100089-100098.

Sample letter of appeal

Provide the following information in the heading of the letter:
Date, Payer Name, Address and Phone Number, Patient Name, Policy Holder, ID#, Group #, Social Security or Patient Identification # and Date of Birth

To Whom It May Concern,

On behalf of my patient, **[patient name]**, I am writing to appeal the denial for Basivertebral Nerve Ablation (BVNA), a procedure that I have deemed medically necessary for the treatment of chronic vertebrogenic low back pain. The denial cites **[rationale from denial letter or Explanation of Benefits (e.g., investigational/ experimental, not medically necessary)]**. I am requesting an expedited review of the denial. Enclosed is supporting clinical documentation of the patient's condition and symptoms reflecting the on-label use of the product. **[If appealing a claim denial, include details of any pre-procedure approval/confirmation of coverage (i.e., predetermination, prior authorization, etc.)]**.

Basivertebral Nerve Ablation (BVNA) is a minimally invasive interventional procedure that uses thermal ablation of the basivertebral nerve (BVN) to treat vertebrogenic pain.

Explain the clinical rationale leading to the decision to recommend Basivertebral Nerve Ablation (BVNA). You may require one or more paragraphs to address the following:

- Thorough description of low back pain:
  - Duration of pain
  - Clinical and/or radiographic absence of non-vertebrogenic pathology
  - Visual Analog Scale (VAS) and functional score
  - Impact to activities of daily living
  - Oswestry Disability Index (ODI) functional impairment score
- Previous conservative medical management (CMM) treatments tried and deemed unsatisfactory (e.g. pharmacotherapy, physical therapy, cognitive support/therapy, epidural/ facet injections, etc.). Include treatment duration/number of sessions and description of pain/ functional response.
- MRI report with evidence of Modic Type I or Type II changes (and specific vertebral body/ bodies)
- Address the benefit/risk profile of any potential relative contraindications
- Past lumbar spine surgeries – confirm none at same spinal level proposed for BVNA
- Mental health statement or psychological screening
- Document the specific vertebral body(ies) to be treated
- State clinical and radiographic findings that confirm the primary pain generator at the proposed level of treatment is the BVN, and not other conditions. If other conditions (such as spondylolisthesis, spondylolysis) are present in imaging explain why these are not the primary pain generator.
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Clinical evidence
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Sample letter of appeal

by the Oswestry Disability Index (ODI) at 3 months.[1] Long-term follow-up results confirmed improvements in pain and functioning were sustained at 24 months and five years post-treatment.[2,3] A second RCT evaluating BVNA confirmed that a significantly greater proportion of treated patients achieved at least the MCID improvement in ODI in the ablation arm (74.5%) vs the standard-care arm (32.7%, P<.001) at 3 months, with results sustained at 24 months.[4,5]

In closing, I have determined that **Basivertebral Nerve Ablation (BVNA)** is not only medically necessary but the most appropriate treatment for my patient for which I have provided the above and enclosed information to support this request. As such, I respectfully request reconsideration of coverage and reimbursement for this procedure. If you have any questions, please contact me at **[phone number]**. Thank you for your prompt review.

Sincerely,
_____, MD

Provider name
Provider NPI/Tax ID

Enclosed: **List of enclosures (e.g., prescriptions, copies of pertinent medical records, along with any other relevant information you believe would make a persuasive argument for coverage such as clinical evidence).**

1. Fischgrund JS, Rhyne A, Franke J, et al. Intraosseous basivertebral nerve ablation for the treatment of chronic low back pain: a prospective randomized double-blind sham-controlled multi-center study. Eur Spine J. 2018; 27(5):1146-1156.
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4. Khalil JG, Smuck M, Koreckij T, et al. A prospective, randomized, multicenter study of intraosseous basivertebral nerve ablation for the treatment of chronic low back pain. Spine J. 2019;19(10):1620-1632
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Additional resources

Coding and payment guide

Click here to access the current coding and payment guide.

Contact us

For additional information, contact the Medtronic Reimbursement Support team:

Email: neuro.us.reimbursement@medtronic.com

Visit our reimbursement website

Patient Access Connect (PAC) Portal

About Basivertebral Nerve Ablation therapy

The ViaVerte RF Ablation System is intended for ablation of basivertebral nerves of the L3 through S1 vertebrae for the relief of chronic low back pain of at least 6 months duration that has not responded to at least six months of conservative care, and is also accompanied by either Type 1 or Type 2 Modic changes on an MRI such as inflammation, edema, vertebral endplate changes, disruption and fissuring of the endplate, vascularized fibrous tissues within the adjacent marrow, hypointensive signals (Type 1 Modic change), and changes to the vertebral body marrow including replacement of normal bone marrow by fat, and hyperintensive signals (Type 2 Modic change).